PRINCIPLES OF CORRECTIONAL THERAPEUTIC COMMUNITY TREATMENT PROGRAMMING FOR DRUG ABUSERS

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Paper presented at the
ONDCP Consensus Meeting on
Treatment in the Criminal Justice System

March 25, 1998

National Development and Research Institutes, Inc.
16th Floor, Two World Trade Center, New York NY 10048

PRINCIPLES OF CORRECTIONAL THERAPEUTIC COMMUNITY TREATMENT PROGRAMMING

The following 25 principles guide the application of successful therapeutic community programming for drug abusers within the criminal treatment system. They are gleaned from clinical experience and sound quality evaluative research into correctional and community-based treatment programming that yielded reduced criminal recidivism and drug use.

A. Diagnosis and classification

The diagnosis and classification process should assist drug using offenders in custody to identify those factors that are highly likely to impel relapse to prior inimical conduct after release, what Andrews et al. (1990) call criminogenic factors. The outcome of the diagnosis and classification process should divide the population into the categories seen in Figure 1 below: (1) those chemically dependent and more amenable to treatment, (2) those chemically dependent and less amenable to treatment, (3) those not chemically dependent but who use non-addicting drugs regularly and are amenable to treatment, (4) those not chemically dependent but use drugs occasionally or less often or who use hallucinatory drugs, and less amenable to treatment. The dimension—severity of criminality—should be examined within these categories.

Figure 1

	Chemical Dependence Prior to Incarceration	
	chemically dependent	not chemically dependent
Amenable moderate Treatment	1. High predatory to property offender **Heroin addicts** **Methadone misusers** **Cocaine users** **Some crack users**	3. Low to property offender **Regular users of non-addicting drugs** **Rx Pill misuse** **Marijuana users**
No or Low moderate Amenability to Treatment	2. High rate violent offender **Chronic polydrug abusers** **Crack/Amphetamine addicts**	4. Low to violent offender **Occasional users** **LSD, PCP, XTC users**

The most powerful intervention process that we presently have in the armamentarium of correctional treatment—therapeutic community treatment—should be reserved for those persons in groups (1) and (2) that have severe predatory criminal records (e.g., highest robbery rates) and nine to eighteen months to serve. Success with category one will yield the greatest benefit-cost ratio and have the largest impact on the quality of life. Success with category two, while less likely, will also yield high gains in terms of crime reduction. If they are retained for six months or more, about 60 to 70 percent of the nonamenable

individuals are likely to change favorably in powerful treatment milieus such as exist in therapeutic communities (Wexler et al. 1988). Persons in group (3) who use non-addicting drugs regularly such as marijuana, should be assigned to less potent treatment modalities such as means-end problems solving skills training or cognitive-behavioral skills training both of which have demonstrated consistent success in well-executed research studies (Platt et al., 1980; Robinson et al., 1991; Porporino et al., 1991; Robinson, 1995). All programming assignments should be governed by the availability of treatment for the identified factors likely to impel return to criminal behavior and drug use after release, i.e., the severity of criminal offending and by the variety, chronicity, intensity, duration, and priority of the person's drug use. Persons in group four are less likely to seek drug abuse treatment *per se*, but may be placed in drug education and may benefit from weekly group counseling.

This flows from research clearly indicating that high risk offenders are likely to show greater reductions in recidivism and relapse to drug use when they receive more intensive interventions and supervision (Andrews et al., 1990). In contrast, low risk offenders are likely to respond to regular levels of treatment intensity, and may drop out and fail more frequently and faster when exposed to intensive treatment such as a traditional TC. Reserving the appropriate intensity of treatment for each level of offender not only makes sense clinically, but is also cost beneficial. For example, applying therapeutic community treatment to once or twice-a-week marijuana users is simply a waste of resources.

It is suggested that amenability for substance abuse treatment may be assessed with the 18 item Factor Based Multimodal Suitability Scales (MSS) (Melnick 1995) and the 18 item Circumstances, Motivation and Readiness (CMR) scale (De Leon et al. 1994; De Leon et al. 1998); the extent of substance abuse/chemical dependence may be assessed with the Addiction Severity Index - 5th Ed. (McLellan et al. 1992).

B. Sequencing and duration

The diagnosis and classification process should also yield a plan for the sequence of interventions, i.e., some program components should precede others while some should be done just prior to release, and for the length of the treatment period. Ideally, the sequence of interventions should be planned for all operating elements of the criminal treatment system through the termination of custody. It would appear that the optimum time to begin serious intervention to achieve the best effects on future drug use and criminality is one year to eighteen months prior to release (De Leon 1995). If therapeutic community treatment is initiated too early and the participant is returned to the general prison population after completion and remains there for three months or more, it is likely to be less effective. If the TC treatment goes on too long (e.g., more than two years), or if the TC is introduced too close to release time when there is less than six months to complete treatment, it is also likely to be less effective. *Timing or sequencing is as important as which elements should be in the program*. Generally, fixing a specific date for completion at the outset of treatment is a mistake. The optimal duration of time for full program involvement should be consistent with TC goals of recovery and its developmental view of the change process.

Six pretreatment stages have been identified by De Leon (1995) through which individual drug abusers pass as they move toward treatment, and four treatment stages as they move toward recovery.

1. **Denial**: Active abuse and/or associated problems, with no problem recognition or problem acceptance

2. **Ambivalence**: Some problem recognition, but inconsistent acceptance of the consequences of continued use on self and others

3. **Extrinsic Motivatlon**: Some recognition and acceptance of drug use and associated problems, but attributed to external influences and not seen as reasons for seeking change

4. **Intrinsic Motivation**: Acceptance of drug use and associated problems and an expressed desire to change based on positive and negative inner reasons

5. **Readiness for Change**: Willingness to seek change options which are not treatment related

6. **Readiness for Treatment**: Rejection of all other options for change except treatment

7. **Deaddiction**: Detachment from active drug use; pharmacological and behavioral detoxification

8. **Abstinence**: Stabilized drug freedom for a continuous period, usually beyond the individual's longest historical period of drug freedom

9. **Continuance**: Sobrieiy plus personal resolve to acquire or maintain the behavior, attitudes, and values associated with the drug-free lifestyle

10.**Integration and Identity Change**: The interrelation of treatment influences, recovery-stage experiences, and broader life experiences resulting in self-perceived change in social and personal identity

Thus, how long the offender must be program-involved depends on his or her stage of recovery, although a minimum period of intensive involvement is required to assure internalization of the TC teachings. TC research indicates that certain treatment periods (9 to 12 months for in-prison therapeutic communities with 6 months in-community treatment for category one persons; 6 to 9 months for category 3 persons; for category two persons,

12 to 18 months with 12 months in-community treatment) seem to produce better outcomes.

How long the resident should spend in the program, however, is by no means universally agreed upon. The Stay'n Out study (Wexler et al. 1988), for example, shows that in-prison therapeutic community outcomes appear to peak between nine and twelve months for hard-core offender-addict inmates participants followed by at least six months in community-based treatment. Another program (Key-Crest) views the time in the aftercare facility or halfway facility as more important—that as little as six months may be spent in prison TC, but 12 to 18 months should be spent in the aftercare facility (Inciardi et al. 1997). Some research (Wexler et al. 1988) does show that prosocial outcomes begin to diminish when men and women are held in programs longer than twelve months and not released, but sometimes this cannot be avoided. Stay'n Out dealt with this problem by creating a cadre of "post-graduate" residents who participate as training staff in week-long training sessions with guest-trainees. Some prison-based TCs have opted to take in some inmates serving life sentences in the hope that the treatment process will convert them into useful "treatment" personnel to help other inmates. While there is some anecdotal evidence of success using "lifers," there are no outcome studies available yet that can tell us whether this strategy is successful in the long run. Until such time, placing "lifers" into prison-based TC treatment should be approached cautiously with careful and continuing oversight.

C. Case management

The process of intervention during the full period of legal custody, needs to be managed. Unmanaged, the process is more likely to be subordinated to management exigencies and important priorities unrelated to treatment ends, and the likelihood of a successful outcome is likely to be reduced, if not extinguished. The case manager in an institution is the single accountable individual who provides assessment, case planning,

advocacy, linkage/ coordination, and monitoring—all relevant functions for institutionalized offenders as well as for those under field supervision. The case manager is the best guarantor of continuity of treatment across the operating elements of the criminal treatment system. Since offenders have multiple needs and service delivery systems are typically fragmented, case management services are essential. Case management by itself in the absence of a strong and viable treatment model, on the other hand, is not sufficient to produce significant or sustained human change. In a correctional TC with linked aftercare no specific case manager is needed; the case management function is handled by the community together with the senior residents and staff. After release treatment continues in the aftercare facility operated under the same philosophy and overall direction.

D. Alignment

In non-TC rehabilitative environments in corrections the custodial and rehabilitation staff ideally should work together cooperatively with the same goals—reducing recidivism and facilitating prosocial change. Normally, however, this is difficult—time, priorities and orientations of both kinds of staff often conflict. Alignment of custodial and program staff can be aided by cross-training and mutual incentives where they both share in the rewards for achieving lowered recidivism. There are several keys to achieving alignment. The case manager is one key because he or she manages the programmatic elements with therapeutic oversight and guidance, and keeps the administration apprised of programmatic events. With intervention activities going on during the length of custody, the case manager is responsible for coordinating intra-agency and interagency services as well as for monitoring progress, facilitating inter-staff liaison, cross-training, information sharing, and managing the transition to the community (i.e., reentry) during the first six months of release, whether or not the offender-client is on parole. It should be noted that the institutional administration's commitment to achieving success is vital for the case

manager's role to be performed successfully. The program will survive and achieve its objectives much more easily when the superintendent values the program and shares the goals of the program; and acts to create in his or her staff a sense of cooperation and optimism.

E. Recruitment and retention

Inmates in the correctional treatment system often need to be encouraged to participate in programs. Simply offering treatment programs to them is unlikely to obtain and sustain a sufficient level of cooperation and participation. Incentives of various kinds may be useful external motivators and several levels of encouragement may need to be explored. For most inmates, the most motivating incentives to enter and participate in program are reductions of time to be served, eligibility for less secure placement, safety, comfort and status rewards.

It is well accepted by the drug abuse treatment community that longer stay in treatment is associated with more favorable outcomes (Hubbard et al., 1989), hence it is appropriate to undertake actions during treatment to enhance retention. Evidence has been accumulating (Condelli & De Leon, 1993; Gostin, 1991; Lewis & Ross, 1994; Platt et al 1988) that legal pressure promotes longer retention for persons in community-based care provided clients entered treatment as a result or condition of the criminal justice system or with the intention of alleviating legal pressure created by that system. Anglin and Maugh (1992) conclude that drug abuse treatment mandated by the criminal justice system represents one of the best and most cost-effective approaches to breaking the cycle of hard drug use, crime, incarceration and recidivism based on research with the California Civil Addict program, other programs, and outcome research on community-based programs with clients with extensive criminal histories.

The retention of clients in prison-based treatment is less a function of coercive legal pressure, however, and more a function of the advantages perceived in remaining in the

program (e.g., safety, comfort, relative freedom) and the anticipation that completing the program will have positive consequences for release. On the other hand, the retention of clients in the ‘halfway house’ program during aftercare, i.e., following release from incarceration, is enhanced by making staying in the program a condition of parole or probation. Nonetheless, the more favorable the program is viewed by the inmates while incarcerated, and the greater the similarity of the community-based phase with the in-prison program’s principles, guidelines and activities, the more likely they are to remain in (and derive benefit from) the community-based phase with or without coercion.

F. Mandatory participation

Success in programs rarely occurs when the treatment is imposed on offenders in an authoritarian fashion, but is enhanced when the offenders are involved in developing their own program of recovery. This appears to be true whatever the form of treatment utilized. The program's intention should be to help prisoners help themselves rather than to “overhaul” them, cure them of their “illness,” or “brainwash” them, or otherwise coerce a change of attitude. Forcing or compelling unwilling offenders to participate in programs (no matter how potent the program and how needful the inmate) should be avoided, since it is unlikely to generate much more than resentment, resistance and minimal change, or worse, faked change indicating apparent compliance. Involving *non-amenable* offenders is likewise unlikely to generate more than a minimal change in behavior, but fortunately it is likely not to foster countereffects. The participants' amenability to treatment is sufficient but not necessary for treatment effects to occur. About 60 percent of *successful* program graduates admit that they entered a treatment program while in prison for other than therapeutic reasons (Wexler et al. 1988). That is, they entered because they wanted to make a favorable impression on the paroling authority, to be in a safer or a more comfortable environment, to receive better food, or because they thought they could "get over" easier or because they might get released or furloughed sooner. Programs that seek

to recruit do so by making entry better than non-entry, and programs with a low attrition encourage sustained participation by making staying in the program more desirable than leaving. They do this by creating an environment that is physically safer, cleaner, and more secure psychologically than alternative custodial environments.

Research into the utility of mandating treatment for felons shows that providing mandated clients with a clear understanding of the treatment conditions and consequences for failure, and making them clearly aware that the system is prepared to enforce and has a record of actively enforcing the conditions, enhances retention in programs. There is more support, moreover, for exposing offenders to the certainty of punishment for failure, than for the severity of punishment such as long jail and prison terms as a way to enhance treatment retention. It is not the actual legal coercion that has major impact, but the inmate's *perception* of legal pressure that apparently increases retention in program (Young, 1997; De Leon, 1998forthcoming).

G. Phased program format

In a TC, the entire treatment protocol or plan for delivery of therapeutic and educational activities is organized into phases reflecting a developmental view of the change process. The phases in the TC are definable points in the development process, and are emergent as the individual resident progresses in relation to his or her exposure to the various community and individual interventions. De Leon (1995) has delineated three main phases or stages: stage 1. induction/orientation about 1 to 2 months; stage 2, primary treatment about 2 to 12 months; and stage 3, reentry, about 13-24 months. Incremental learning is emphasized at each phase. This learning moves the individual to the next stage of recovery. This does not assume that the process is simple or smooth. In fact, change is erratic, gradual, and subject to relapse. Change is seen in usually small increments. Since change occurs in the TC through trial-and-error learning, behavioral consequences are followed by objective consequences (e.g., discipline and rewards) as well as experiential

or subjective outcomes associated with these consequences. Changing a resident in a TC involves a variety of perceptual and experiential mechanisms in the process. Both observable behaviors as well as subjective perceptions and experiences are essential mechanisms linking interventions with behavioral change. These elements in the process may appear gradually in the daily regime of the TC or as critical striking occurrences. The latter are distinctive moments of individual change involving a critical experience that appears to singularly influence change in behavior, insight and/or commitment.

In the community-based TC as in the prison-based TC, the second stage of the TC process, or Primary Treatment, focuses on the main social and psychological goals of the TC. This stage consists generally of three phases that correlate roughly with time in the program (2-4 months Junior Resident; 5-8 months, Intermediate Resident; and 9-12 months, Senior Resident). Thus, these phases correspond with the member's status and responsibilities in the community and are definable by plateaus of stable behavior that signal the need for further change. While these phases correspond in the prison-based program, the phase periods in prison are usually shorter, with reentry coming prior to release on parole to the community-based TC that will continue the reentry phase.

In a community-based TC, the third stage, Reentry, consists of two phases: early (13-18 months) and late (18-24 months). In a prison-based TC these two phases are spent partly in the prison, but mainly in the community-based TC. The main goal of reentry is preparation for healthy separation from the TC community. Residents in early reentry continue to live in the facility but may hold jobs or attend school while still being expected to participate in the facility's daily activities and to fulfill community responsibilities. Late reentry or aftercare is distinct because it involves a successful separation from residency. TC members now live out, are involved in full-time jobs or education, maintain households—sometimes with peers and sometimes restored to their own families. They often also participate with others in Alcoholics Anonymous or Narcotics Anonymous or

take part in individual, group or family therapy. Program participation, however, does not cease. Two excellent examples of reentry facilities for prison-based TC treatment are Serendipity House associated with Stay'n Out in New York and Vista in San Diego associated with the Amity at Donovan program. The Crest reentry facility variant in Delaware is a work-release program for program graduates from the Key program. The research clearly indicates that achieving the optimum effect of prison-based TC treatment is inextricably linked to the treatment continuing in the community after release. (This principle and several subsequent ones (J) are delineated in much greater detail in the framework set forth by De Leon in his 1995 publication xx.)

H. Orientation

Success in TC programs is also enhanced by orienting participants during the recruitment phase, and again in the induction phase of service delivery, and again prior to termination or release to the community—the reentry phase. In the first month of the recruitment phase orientation is used to: (1) strengthen readiness by facilitating the inmate's decision about needing treatment; (2) modify the inmates' acceptance of the treatment modality, and reduce anxiety through information about what experiences they are likely to encounter, and what realistic expectations from the program they should have; and, (3) reinforce early gains in behavior change, newly learned attitudes and active engagement with program staff. Programs that achieve higher retention also have senior personnel conduct the orientation rather than leaving it to relatively inexperienced staff. Similarly, such programs attempted to reduce the ambiguities of the prison treatment experience by specifying behavioral expectations and decision criteria for phased movement or program status changes (De Leon 1994). The use of peer role modeling and peer pressure constitute essential elements of TC treatment programs and are particularly important during the early phase. When inmates first enter treatment, they usually exhibit characteristics learned on the streets and in the general prison population such as isolation,

braggadocio, distrust, dishonesty, and denial. Peer pressure, especially through group sessions, is used to confront an inmate's denial of his or her drug problems. Peers that have made progress in treatment often have the skills to engage in honest and open communication. Positive peer pressure helps inmates speak honestly and to confront realities about themselves. In the process, new inmates learn that open confrontation can be tolerated and can lead to positive changes in behaviors and self-confidence. Inmates come to view peer pressure as a form of support in which other inmates provide a sense of community and family. At the time of release, it is also important to orient the families of participants about the program the inmate has just been through, what to expect from him (or her) during the first few weeks of freedom, what continuity of programming is planned, and how best to provide support during the first six months in the community.

I. Communication

Thoughtful and open communication between program participants and treatment staff provides a level of mutual trust that supports program integrity (Hollin 1995). Moreover, the public nature of shared experiences in the community is used for therapeutic purposes. One’s feelings and thoughts are matters of importance to the recovery and change process, not only for the individual but for other members as well. All personal disclosure is eventually publicly shared. An interesting aspect related to communication is the use of TC argot. This is a special vocabulary used by residents to reflect elements of the TC’s subculture, particularly its teachings regarding “right living” and recovery. The beliefs and values which serve as explicit guidelines for self-help recovery and “right living” are expressed in this vernacular expressive of and unique to the peer culture of each TC. The gradual shift in attitudes, behaviors, and values consonant with recovery and right living is mirrored in how well residents learn, understand and use the argot (De Leon, 1995). As with any special language, TC argot represents individual integration into the peer community’s subculture, but it also is a measure of one’s affiliation and socialization

in the therapeutic community, and hence, is an expression of and unit of measurement for the individual's clinical progress during treatment.

J. Creating the TC environment

Correctional-based therapeutic community programs have their own names, often created by the residents themselves. In community-based TCs residents remain away from outside influences twenty-four hours a day for several months before earning short term day-out privileges. This facilitates gradual detachment from old networks and permits the development of relationships among drug-free peers in the program. In the prison-based TC isolation from the "general population" has the same effect. The physical setting in the TC facility contains common spaces to promote a sense of commonality for collective activities, e.g., groups, morning meetings, evening seminars. The walls typically display signs stating the philosophy of the TC in simple terms including messages of "right living" and recovery. Corkboards and blackboards identify all residents by name, seniority level, and job function, and daily schedules are posted. This daily reinforces and reifies the organizational structure of the program, broadcasts whatever changes occur in the relative positions and functions of the residents, and facilitates the individual's identification with the organization, which in turn promotes greater affiliation. As one ascends in function and responsibility, the organizational board is testimony to one's accomplishments in the program.

To sustain the communal character of the TC and to enhance effectiveness, treatment or educational services are provided within the peer community context. Thus, the primary source of instruction and support for individual change is the peer membership. Providing authentic reactions and observations to others is the shared responsibility of all participants. Hence, except for individual counseling, all activities are collective including at least one meal a day; the daily schedule of meetings, groups, seminars; all team job

functions; organized recreation and leisure time; and, all ceremonies and rituals (such as birthdays, phase graduations, significant milestones).

The TC day is highly structured. Ordered and routine activities counter the chaos that typically characterizes the daily lives of the residents before entry. Likewise, order and routine create distraction from negative thinking and boredom—factors which predispose drug use. Moreover, structured activities facilitate the development of self-structure for the individual, including time management; planning, setting and meeting goals; and developing accountability. Regardless of its length, the day has a formal schedule of varied therapeutic and educational activities with prescribed formats, fixed times and routines (De Leon, 1995).

K. Clear rules of conduct

For participation in programming to have optimum effectiveness, clear unambiguous rules of conduct while in a prison-based TC program are established to ensure that all participants understand the rules, and, as well, understand the sanctions that will be applied for their violation. Rules, regulations, and social norms protect the physical and psychological safety of the community. Cardinal principles are established for totally unacceptable conduct in a therapeutic setting, i.e., conduct that would seriously undermine the integrity of the program (e.g., assaulting a fellow resident or staff person; possessing illicit drugs and sexual misconduct). For authentic accountability to develop, residents must know that violating a cardinal principle will be met with instant dismissal, and that violating a lesser principle will be immediately confronted and disciplined. Lesser violations include being late to sessions, talking back except where appropriate in a group confrontation, not fulfilling one's responsibilities or job requirements, being tardy to a meeting, etc. Lesser rule breaking is met by immediate confrontation and consensual discipline. Ambiguity in rules or in the system's response to rule breaking does not stimulate effective learning, but, in contrast, fosters the idea that a participant can "get

over" or get away with rule violation. The community's behavior and attitude reflect the value that compliance with rules is valued, recognized and rewarded, and that noncompliance with rules will be consistently met with immediate negative consequences, and that this is valued and shared by all participating members.

Another side to this issue is the use of structure and systems. The organization of work needed to maintain the daily operations of the TC area (including the varied job functions, tasks, and management roles) is the main tool for teaching self-development and responsibility. Learning occurs less through specific skills training, but more through compliance with the orderliness of procedures, rules and systems, in accepting and respecting supervision, and in behaving as an accountable and responsible member of the community upon whom others rely. In a community-based program all residents are responsible for the daily management of the facility including cleaning, activities, meal preparation and service, maintenance, painting, purchasing, security, coordinating schedules, preparing for meetings, seminars, etc. These functions strengthen affiliation with the program through participation and provide opportunities for personal growth and skill development. The functions also foster self examination by increasing responsibility to others and challenging self-limited performance levels.

In a TC modified for a correctional facility, however, certain functions may not be available such as meal preparation, purchasing, and security, thus surrogate functions must be created. The functions residents can perform in prison are governed by the rules of the facility and vary across programs. Many organizational and work functions can be created within the housing, recreational and educational spaces available to the TC within the prison walls. Nevertheless, the therapeutic community perspective toward work as a fundamental therapeutic principle is consistent across programs.

L. Positive and negative sanctions

Good TC programming uses joint needs assessment and offers strong positive incentives for continuing active and positive participation. Such incentives are jointly agreed to by inmates and staff rather than imposed by staff. Offender-clients seem most amenable when they are offered a choice of incentives rather than only one (which may or may not have value for an individual). Thus, TC programming involves the establishment by staff of clear consequences or contingencies for desired and undesired behaviors. For example, the use of contingency contracting wherein inmates and staff jointly work out progress steps (e.g., skill levels in an occupational area) that the inmate agrees to work toward achieving by specific dates. A single reward offered to all is risky. In order to be effective an incentive must have value and meaning for the inmate.

Programs enhance residents' opportunities for personal development by disseminating the rules of their contingency program very clearly to ensure that participants understand how rewards such as more privileges and better living circumstances can be earned, as well as what behaviors are undesirable and what the penalties are for such activity. This is usually done during orientation. Moreover, clear rewards such as increased privileges, early release, better housing, better clothes, more recreation time, better food, better jobs, more pay is used to motivate participants to stay in programs and to participate with greater vigor—in other words enhancing retention and eager participation.

Among rewards, it is our experience (Lipton 1997) that time incentives appear to be the most motivating, followed by eligibility for less secure placement, personal safety considerations, comfort and status rewards. The particular combination of motivating factors that are most effective for an individual, however, is idiosyncratic to the institution and the individual. Program time contracts, that is, promising early release for satisfactory program completion generally have the most promise for motivating participants as well as reducing costs and overcrowding. Lower security contracts, that is, promising transfer to a less secure facility, or to a work release, or halfway house or camp for satisfactory

completion of components of program are useful motivating factors and reduce the costs of incarceration. Likewise, negative sanctions such as loss of good time, loss of pay, transfer to more secure custody, lesser housing (less privacy, less comfort), worse job assignments with distinctively stigmatizing uniforms for failing to meet contingency contracts are also powerful motivating factors. For every set of rewards there should be an equally potent set of negative sanctions which may be applied for failure to produce desired changes or objectives.

Staff can also be motivated to achieve desired objectives by rewarding them for their inmates' achieving desired outcomes (e.g., infraction-free months before release, recidivism-free months (or quarters or years) after release). It is often not enough to expect optimum performance by staff by only allowing an employee to continue his or her employment. Rather this leads to complacency and inertial performance. The use of performance-based contracting along with staff meetings and seminars, on the other hand, may be a practical means to motivate staff’s continued commitment and adherence to program goals and to reward the achievement of desired outcomes as well.

M. Isolation from prison subculture

It is important to separate participants from the general population as soon after they enter treatment as possible. To succeed TC programming must neutralize the effects of the inmate subculture or prison code by housing and working with the participants in areas where they are not in contact with the general inmate population. It is virtually impossible for a genuine *community* to be created and sustained successfully if its members return to the general population at the end of each day. If the day’s program occurs in an isolated environment, but the inmates are returned each day or every few hours to general inmate housing or recreation areas, where they participate with the general population, the pervasiveness and power of the inmate subculture will undermine most, if not all, the rehabilitative gains made earlier.

In the same vein, prison-based TC programming requires participants to relate frequently to staff and to each other (i.e., other program participants) in daily meetings, and require them not to relate to general population inmates. It is best for the sustained progress for program participants to be housed in isolated living units where as many other services as possible are also provided (e.g., vocational training, social skill development, rehabilitation sessions, counseling, group meetings, recreation, and food service). Total isolation is ill advised, however. It should be noted that some contact with the general population may be allowed, e.g., on the ball field, or during meals, in vocational training shops. This minimal contact reminds participants how much they are changing from the general population, and it reinforces and accelerates their progress. Extensive contact with the general population, however, is likely to undermine the therapeutic progress, and in some cases generate conflict.

"Jailing" is the term used to describe the maintenance of the prison subculture in a halfway house or in similar community-based correctional treatment settings. Jailing almost always will occur if the facility is maintained primarily as a correctional facility and not as a treatment facility. There will be order and compliance, but little treatment and minimal human change—most inmates will attempt to "get by and get over," even if they were initially motivated. There is also a great risk that the power structure in a "jailed" facility will cause allegiances to shift to the same power base that existed in the incarceration facility. Thus, it is equally important that the principle of isolation needs to be maintained in the reentry facility to achieve optimum results.

N. Maintenance of program integrity

An essential element of any kind of successful treatment programming is ensuring the integrity and quality of the program itself. The effectiveness of any intervention is dependent upon the rigor with which that intervention is conducted, and this in turn, is dependent on the presence of well-trained and skilled practitioners, their sustained

commitment to the desired treatment process and outcome, and the consistent involvement of the treatment initiators in all the operational phases of the program. Even if a program is well designed and its shakedown period successful, it is subject to drift over time and to the use of replacement staff (who are typically not as committed nor as well trained) who begin taking key roles. It is axiomatic that certain trends occur over time: institutionalization; a lessening of enthusiasm; a shift in attention from quality service delivery to administrative compliance; and a loss of focus on the theoretical basis or the human change model that underpins the program.

To prevent this decay, direct observation of program implementation is needed on a daily basis to detect that it is occurring. Every program should have a good treatment manual firmly based on respectable theory with detailed guidelines for the design, setting up, and running of the program. Especially important are clear statements of mission, clear statements of policy regarding staff and client behavior, curricula for staff orientation training and in-service training, provision of supervision for staff with adequate support and feedback, suggestions for practice (e.g., how to construct role play with vignettes), how to handle difficult or tricky situations, and a system of accountability for staff and for participants. The latter refers to an acceptance of the fact that practice should be informed by evaluative data gathering according to the rules of scientific inquiry (Hollin, 1995).

O. Accentuate the positive — Eliminate the negative

Another element of good TC programming involves emphasizing prosocial behaviors rather then attempting to reduce directly the frequency of criminal, unhealthy or antisocial acts. TC group meetings and seminars do not give *undue* attention to negative behaviors, but focus on positive behavior alternatives, and use cognitive-behavioral techniques to attempt to create a reservoir of positive alternatives and problem solving options. Focusing on negative behaviors tends to encourage thinking about how to improve law breaking so as not to get apprehended, and how to use negotiation skills to avoid being arrested, rather

than avoiding the illegal conduct. Also, for drug addicts, dwelling on drugs, drug using behaviors and drug transaction experiences, and discussing paraphernalia tends to foster craving. Also, these topics allow them opportunities to re-experience positive drug-related events publicly, and this generates anticipation about continuing drug use upon return to the community, and encourages the acquisition of contraband drugs in the institution. Residents generally recognize when one of their fellow community members is using drugs and, where a genuine ‘community’ has formed, move quickly to confront that behavior. Experienced participants also strive to model the change process. Along with their responsibility to provide feedback to others as to what they must change, residents themselves are exemplars of change, and they also provide examples of how change comes about.

P. Ex-offender/ex-addict staff as role models

The TC staff should be a mixture of self-help recovered professionals and other traditional professionals (e.g., educational, medical, mental health) integrated through cross-training and grounded in the basic concepts of the TC perspective and community approach. Regardless of professional discipline the generic role of all staff is that of community members who are rational authorities, facilitators, and guides in the self-help community method. Program-trained former addict-inmates who have graduated treatment programs and have demonstrated good work histories for at least three years in the community can be of extraordinary value as counselor/role models in a prison-based TC treatment program. The employment of ex-addict-offenders in the treatment of current drug abusers in a variety of progressively more responsible roles has clearly been of benefit to the patients in programs and has helped the drug treatment system function more effectively. In prisons where therapeutic community programs for treating drug offenders are in place such as at the Stay 'N Out Program in New York (for both men and women), at the Amity Donovan Program in California, and at New Outlook in Alabama, they serve as

powerful role models to the offenders they treat. The ex-addict offenders (all of whom are therapeutic community graduates themselves) are the role models whose presence demonstrates the realistic possibility of achieving successful rehabilitation. They speak the language of the street drug users and can generate trust easier than professional clinicians. Additionally, they can understand the feelings and concerns of the drug abusing patient as well or better than professional clinicians. This is not to conclude that only recovered persons can be effective treatment agents in a therapeutic community setting. Notably, at the Cornerstone Program in Oregon, at the time of its closing, the staff mainly consisted of professional psychologists and social workers. This program had roughly the same effectiveness as the Stay'n Out program, but operated at more than three times the cost.

Research studies evaluating the effectiveness of therapeutic communities in correctional settings demonstrate, both statistically and clinically, that, in these types of settings in particular, the ex-addict offenders working as clinicians are as or more effective than academically-trained clinical staff alone or up-graded correction officer/counselors alone in rehabilitating the drug offenders (Wexler 1995). Comparisons of effectiveness have been made with milieu therapy programs run by correctional treatment staff and with supportive counseling programs run by trained clinicians. The results indicate that graduates of programs with ex-addict-offender clinicians are less likely to fail during the post-release period than graduates of programs that do not include recovered persons. Optimal results seem to occur with the combination of ex-addict-offenders, themselves graduates of a therapeutic community, and especially-trained volunteer correction officers who choose to work in a prison-based therapeutic community. This, of course, is not to preclude the active participation of mental health workers or corrections-employed rehabilitation and counseling staff so long as they are thoroughly trained and experienced using the self-help community method with chronic drug users.

It must be noted, of course, that not every graduate of a therapeutic community can effectively perform the role of clinician. Graduation from a therapeutic community drug treatment program, evidence of successful integration into community life, and additional training are *necessary* for such ex-addict-offenders prior to their being acceptable as clinicians. Their para-professional skills need to be honed carefully and they must have personal commitment and integrity to be effective. They need to be supervised carefully as does any professional clinician in the prison-based therapeutic community setting, and they also need to have access to regular meetings with a self-help group comprised of recovering persons like themselves.

The paraprofessional ex-addict-offender in a treatment role, having "been there", is especially able to relate to the special problems of the recently addicted offender, serves as a pro-social and powerful role-model of successful rehabilitation, and allows him or her to pay back to the society some of what they took away before their own social restoration. In addition, the use of such persons in treatment provides steady and productive employment for them in a supportive setting where they know they can be most useful, and where they can “pay back” for past behaviors.

There is a distinct role for <u>trained</u> correction officers who serve as co-therapists, and important advantages accrue to their participation. Their partnership in the therapeutic process demonstrates to the participants that some authority figures are trustworthy and genuinely interested in their welfare. They are sometimes the first examples of persons in authority that inmates meet who are therapeutic in orientation. They also serve as communicators of the programmatic methodology, operations and philosophy message back to the correction officer body. Thus, they serve as a bridge across the “we-they” gulf that normally exists between treators and officers and inmates. They serve to help legitimize the program in the eyes of the administration and to the correction officers’ labor union. Regarding training, correction officers should not assume co-therapist roles

until they themselves have spent between six and twelve months in a therapeutic community program, and been trained there specifically for correctional-based therapeutic community programming. Rehabilitation workers trained in traditional mental health or social work roles will not find most of their skills transferable to a modified prison-based therapeutic community setting. Hence, hands-on TC education and skill building are necessary even for traditionally trained workers.

To summarize this important point, ex-addict-offenders represent a valuable resource to prison-based treatment programs. Ex-addict-offenders act as role models as staff members or when serving as volunteers. Inmates need to be exposed to recovering persons who have had similar experiences and who have made progress. Ex-addict-offenders who have made a successful recovery help addicted inmates learn that recovery is a realistic possibility. They model community living, coping skills, and abstinence from drugs. In the event that correctional agencies are prohibited by law from employing ex-addicts or ex-offenders as counselors, contracting with a private provider such as a community-based TC often makes this possible.

Q. Establish continuity of intervention

Changing a drug abuser's lifestyle is a difficult and time-consuming process. To be effective, drug treatment programming cannot end when an inmate leaves a correctional facility, but should continue in a planned and sequenced manner from the outset of custody through to the legal termination of custody. This must be strongly emphasized—programs that begin within the prison's wall must continue into the community after the inmates release. Moreover, they should continue for the entire length of time that the criminal justice system has custody. Sound TC programs foster the continuation of important elements from the institutional phase of programming into the community.

The experience of reentry after treatment for an offender who is a former drug user is extremely perilous and difficult because of all the triggers to relapse that are encountered

upon returning to places where drugs are sold and used. In the event there is no halfway facility where the re-entering offender may continue treatment, it is essential to strengthen paroling authorities with immediate program referral options (e.g., referrals to community-based treatment programs) and direct service options (e.g., mandated short residential stay in a halfway facility) for former drug abusers being released on parole. The clinical optimum clearly is the actual continuation of the program in a halfway facility or work release facility. (NY's Stay'n Out with Serendipity House; DE's KEY with CREST Work Release; CA's Amity at Donovan with Vista are examples.) Successful programming also involves initiating joint reentry planning with parole/probation staff at least three months before a program participant is released. The TC staff contract with the parolee as part of this planned reentry and provide escorted referral to a private community-based treatment program or to a halfway house where the process of prosocial change continues. Such a reentry process is counterproductive if the exiting offender is transferred to a community-based TC requiring starting the program over from orientation phase as if they had never been through a TC.

The purposes of the reentry planning is for ensuring the continuination of the therapeutic process established during incarceration, and for re-establishing housing, employment and family relationships. For the homeless releasee, residence in an Oxford House for a period of time is not sufficient unto itself to prevent recidivism, but it is a place where one can live and receive group support while treatment continues at a program in the community. The average length of stay in an Oxford House is 13 months, but an individual may remain as long as rent is paid and house rules of sobriety and responsibility are met (Molloy 1992). There are now 568 Oxford Houses all rented by their residents without a single taxpayer's dollar. It should be noted that these are not treatment facilities or programs, just residences. Although there are no scientific evaluations of Oxford Houses, the record of the men and women in these houses appears to be mixed. Many

have remained free of substance abuse for extended periods of time—it is a condition required of those in residence.

R. Detection and surveillance

It is important to emphasize the utility of regular urinalyses in all institutions. Newly admitted participants to the prison-based TC who are not yet inculcated with program values are particularly vulnerable to the temptation to use contraband drugs when they are available (and in most institutions, they are available). Institutions typically specify how offenders in the institution, including residents in the TC, will be targeted for testing (e.g., at admission; return from the community; randomly; for cause; as a condition of supervised release) and they typically specify in clear policies what the result of a drug positive finding will be including interventions and sanctions.

In a prison-based TC, detection of drug use in a resident mandates the effective management of a potential TC program failure. Thus, for example, a resident may be sent back to the lowest entry level for having a confirmed drug positive test result the first time he is tested, and then targeted for more frequent urinalyses. Every TC needs to establish and maintain a solid reputation in the facility and within the larger correctional department. Drop outs and expulsions are likely to produce negative connotations that may misrepresent the TC program to those watching the program. If a resident fails a second time he or she may be expelled from the TC program depending on the rules of the TC. The expelled inmate may become bitter or hostile and vocal about his (or her) expulsion, and characterize the TC very negatively misrepresenting activities in the TC. He or she may become depressed upon reentry to the general population presenting the prison staff with a management and a mental health problem, and the inmate population with a wrongful impression of what the TC produces. To deal with such potential situations, TC staff should conduct exit interviews to help both staff and resident learn from failure. Debriefing can put past actions into perspective and prepare the ex-resident for a new

programmatic beginning. Confidential discussion with the prison caseworker about the ex-resident helps set the record straight and insures some kind of continuum of care for the terminated individual. Most importantly, the TC staff extends a lifeline to a terminated resident allowing the opportunity to return after a cooling off period.

As in the case of all offenders at the time of release, drug users particularly hard-core users, are anxious as the day of release draws closer. This emotion—anxiety—is particularly difficult to manage for recovering persons because of the long history of dealing with anxiety with drug use. Thus, released former drug users are highly vulnerable to relapse. As Rawson (1990) has pointed out, there are hundreds of triggers to relapse for each offender returning to the street. At the outset released drug offenders are highly prone to trying out their rediscovered freedom by fulfilling their long-harbored sexual and drug-using fantasies. In consequence, frequent urine surveillance (that is, at least three times a week or more) is strongly advised. Such urine surveillance must be undertaken with a detection method of sufficient sensitivity to detect cocaine with accuracy. Enzyme Multiplied ImmunoAssay Technique [EMIT™] or a more sensitive detection method is strongly advised. Experienced parole and probation officers who believe they can detect signs of drug use are wrong two out of three times in empirical tests (Wish & Gropper, 1990). Less sensitive methods such as Thin Layer Chromatography will also fail to detect cocaine when it is present most of the time (Wish & O'Neil, 1991). The high level of urine surveillance should be reduced as visits occur without violation (i.e., urine positive for drugs). Successful programs tie the fulfillment of contract contingencies and extended periods of being drug free to increased liberty from urine surveillance and decreased frequency for counseling or casework visits. Conversely, they tie "dirty urine" results to the loss of liberty and increased surveillance.

S. Augment program with model elements that work

Use the social learning model and build cognitive-behavioral skills Successful interventions are often based on a social learning model that treats criminal attitudes and behaviors as learned habits which can be changed by teaching and reinforcing new, non-criminal attitudes and behaviors (Andrews & Bonta 1994; Gendreau 1996). 'Cognitive-behavioral skills' is actually a label for a broad range of intervention methods (McGuire & Priestly, 1995) including contingent reinforcement, contingency contracting, stimulus satiation, behavior modification, shame aversion therapy, relaxation and systematic desensitization; social skills training (modelling, negotiation training, guided group discussion, interaction skills training, assertion training); self-instructional training (e.g., anger control training, cognitive restructuring, biofeedback); aggression replacement training; training in moral reasoning, and multi-modal programs such as Reasoning and Rehabilitation™, a cognitive skills training package which includes many of the components listed above. Offenders with wider repertoires of problem solving methods as a result of problem-solving skills training, life skills training and consequential thinking training, are enabled to cope better with personal and social difficulties without resorting to anti-social methods, encountering failure and relapsing to substance misuse. Many of these techniques or variants of them are components of the holistic treatment that occurs in a therapeutic community.

Teach relapse prevention

Offenders who are taught to recognize and cope with situations where there is a high risk of relapse to drugs and criminal behavior are much better able to resist such encounters after release. Many aspects of relapse prevention are cognitive-behavioral based on the notion that changing an individual's perceptions and underlying beliefs are potential means of altering behavior. Relapse prevention provides tools to avoid triggering a first lapse to drug use as well as for preventing a minor lapse from become a full relapse. Gradual exposure to high risk situations builds up self efficacy and an improved perception

of personal abilities to cope. During the 1980s, relapse prevention became a widely adopted strategy in the treatment of drug abuse. Excellent models for this program element exist (Marlatt and Gordon, 1985). The likelihood of success of relapse prevention with disenfranchised populations, however, is improved if the offender has reached the reentry stage of TC treatment and demonstrated clear progress toward achievement of a prosocial lifestyle (Wexler, 1995).

Use whatever works

In correctional settings, programmatic elements ebb and flow as fads in rehabilitation occur. Thus Relaxation Therapy, Moral Reconation, Acupuncture, Anger Management, Transactional Analysis, Transcendental Meditation, and other programs win and lose advocates during any decade. Yet, each has elements that are likely to be useful to augment the treatment regimen. This is because they each reach people differently and are effective for some in terms of reducing infractions and tension. For others, they combine with programmatic elements of the TC in serendipitous ways to foster positive change. For still others, they appeal emotionally and can be added if their clinical input does not clash with the existing program philosophy. Generally, the aura of enthusiasm and optimism that typically characterizes a new program are factors that ensure at least some positive changes and at least some devoted followers. Unfortunately, these changes are short-lived unless the program has a strong theory-based human change technology that can sustain the change process over time.

CONCLUSION

Treatment in the prison-based therapeutic community creates a social and psychological environment conducive to bringing someone to recovery. The aims of treatment in this respect are global—to change the negative patterns of behavior, thinking, and feeling to develop a responsible drug-free lifestyle. Stable recovery requires successfully integrating conduct, emotions, skills, attitudes and values (De Leon 1995). Moreover, behavioral

change is unstable without insight, and insight is insufficient without felt experience. Thus, enduring change in lifestyle and a positive personal-social identity requires a global approach focusing on lifestyle, rather than drug abuse, criminality or any one problem alone. The process of human change during tenure in a prison-based TC may be seen as a passage through stages of incremental learning wherein changes at each stage facilitates change in the next stage, each in turn reflecting movement toward recovery. Recovery, however, depends on positive and negative pressures to change, and remaining in treatment requires continued motivation to change. Successful TCs provide elements in the daily regimen that are designed at the program level to sustain treatment integrity and, at the client level, to sustain motivation and to detect premature termination signals. As De Leon (1995) puts it, "...treatment is not provided but made available to the individual in the TC environment, in its staff and peers, the daily regime of work, groups, meetings, seminars, and recreation. However, the effectiveness of these elements is dependent upon the individual who must fully engage in the treatment regime. Self-help recovery means that the individual makes the main contribution to the change process." And, "...each individual in the process contributes to change in others." with all elements "...mediated by peers through confrontation and sharing in groups, by example as role models, and as supportive, encouraging friends in daily interactions." Recovery in the social learning model involves altering offenders' negative behavioral patterns, attitudes and dysfunctional roles which were learned in interaction with a dysfunctional family and with delinquent and criminal peers; thus, recovery depends on learning by doing and participating as a community member in a variety of socially responsible roles. This is acquired by acting these roles, and through training to avoid anger or other triggering emotions. Changes in lifestyle and identity are gradually learned through participating in various roles in the community, supported by the other community members similarly engaged in the learning process, and a trained, experienced and highly supportive staff of recovered ex-offender-

addicts, and professionals. It is clear from the research that the process only begins in the prison, and, to be genuinely and lastingly effective, it must continue in the community. Although therapeutic communities have a mixed past, there are now explicit theoretical underpinnings for guiding the development of this modality, but an insufficient number of well-trained recovering persons to staff them. One significant need in this regard is for an academy for training recovering persons and clinical professionals to become credentialed staff to serve the growing number of therapeutic communities in correctional settings. Models for such experiential training exist in the Phoenix House and Stay'n Out therapeutic communities. A potent modality is rare, hence it makes sense to consider evaluating the therapeutic community approach in the treatment of sex offenders and violent offenders as well.

One last note: claims of success made by evaluators of the concept-based therapeutic community, whether community-based or prison-based, are frequently viewed as suspect because of alleged "creaming." Creaming at its most Machiavellian meaning may be unofficially defined as intentionally selecting the best prospects to stay in the program, and deliberately discharging those likely to fail, so one "looks good" by ending up with the most motivated and favorable candidates. There does not appear any evidence that this intentional creaming occurs. At its least Machiavellian, creaming can be defined as allowing natural *attrition* to occur by administrative and punitive discharge, and voluntary withdrawal, thus graduating the most motivated and favorable candidates. Unfortunately the term creaming carries a pejorative connotation.

Attrition during the TC regime is due chiefly to two factors: self selection and staff deselection. Among those persons who opt for treatment, self selection factors contribute to their retention in and compliance with the treatment regimen, and thereby to treatment efficacy. Treatment outcomes, such as retention or behavioral improvement, reflect a complex interaction of selection factors and treatment influences. In the interaction, self

selection factors are dynamic rather than static—they are continually changing, as an effect of the treatment itself. TC patients' fears, cognitions, perceptions, and feelings about their addiction, crime career, their life circumstances, and needs for treatment alter during the course of treatment—these changes influence their decisions to stay, leave, or to enter subsequent treatments. It is a natural process and unique to the individual, rather than a manipulated one. Current versions of recovery stages converge on a developmental view of change which depicts the addict as moving from a status of active use and problem denial to stabilized abstinence and longer term maintenance of a drug free status (Prochaska et al. 1992). Recovery progress is directional but erratic, marked by backward and forward steps. Some of the backward steps are perceived as serious enough to warrant withdrawal although specific interventions or assistance are employed to try to hold individuals in treatment through the personal crisis. Self selecting out of treatment despite efforts to retain such persons then is viewed as appropriate to the process. Motivational and readiness factors are viewed as requirements which treatment must sustain for recovery to occur.

Self help, however, is not equivalent to self change; that is, selection factors alone are not sufficient for recovery—the individual must engage in and utilize those activities which change their behaviors, thinking, perceptions and feelings. This is exemplified in the TC argot: "You alone can do it, but you cannot do it alone." Self change occurs in a community of engagement in which the social, educational and therapeutic processes and resources which guide and facilitate recovery are utilized (De Leon 1997). When individuals, for whatever reason, sufficiently breach the operating rules of decorum so that it is no longer possible to function within the group setting, or break the cardinal principles of the TC, they are 'deselected' from the residence or program setting. This is typically a joint decision of staff and community senior members who can no longer tolerate the offender's actions, usually after many opportunities and counseling sessions are given to

engender positive behavior change. Such persons are not summarily removed—reasons for discharge are explained, and the length of time and conditions for seeking return are offered. Since the primary instrument of change is the community itself, the community cannot tolerate and must reluctantly remove individuals who are destructive to that entity. Other persons are discharged from the TC for administrative reasons unrelated to their progress in treatment or to their behavior in the TC, e.g., transfer to another institution, ill health, warrants for other convictions activated.

The process of recovery involves persons interacting with the community in a process of ‘curing’ themselves. Persons themselves are at the core of the change process, thus choices to enter and to leave the TC are appropriately part of that interaction between the individual and the TC, and should be viewed from that perspective.

References

Andrews, D. A. et al. (1990) Does correctional treatment work? A clinically-relevant and psychologically-informed meta-analysis. *Criminology*, 28, 3, 369-404.

Andrews & Bonta 1994

Anglin, M. D. and Maugh, T. H. (1992) *Overturning myths about coerced drug treatment*. Report from UCLA Drug Abuse Research Center, February 16, 1992.

Condelli, W. S. & De Leon, G. (1993) Fixed and dynamic predictors of client retention in therapeutic communities. *Journal of Substance Abuse Treatment,* 10, 11-16.

De Leon, G. 1988. Legal pressure in therapeutic communities, pp. 160-177 in C. Leukefeld & F. Tims (eds.) *Compulsory treatment of drug abuse research and clinical practice*. ADM88-1578. Rockville, MD: NIDA, USGPO.

De Leon, G. and Melnick, G. (1992*) Therapeutic Community Scale of Essential Elements Questionnaire*. Center for Therapeutic Community Research, NDRI. NY: Community Studies Institute, Inc.

De Leon, G. (1994a) Therapeutic communities. In M. Galanter and H. Kleber (Eds.) *The Textbook of Substance Abuse Treatment*. Chicago: American Psychiatric Press.

De Leon, G. (1995) Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions*, 30, 12, 1603-1645.

De Leon, G. (1997) Reconsidering the self selection factor in addiction treatment research. *Journal of Addictive Behaviors* (forthcoming).

De Leon, G. Melnick, G. Kressel, D., & Jainchill, N. (1994) Circumstance, motivation, readiness, and suitability (The CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse*, 20(4), 495-515.

De Leon, G., Melnick, G., Wexler, H.K., Thomas, G., & Kressel, D. (1998) Motivation for treatment in a prison-based therapeutic community. Center for Therapeutic Community Research at NDRI, New York, NY. (1998, in press).

De Leon, G. (In press). Commentary: Reconsidering the Self Selection Factor in Addiction Treatment Research. *Psychology of Addictive Behaviors*.

Gendreau, P. 1996

Gostin, L. (1991) Compulsory treatment for drug-dependent persons: Justifications for a public health approach to drug dependency. *The Milbank Quarterly*, 69, 561-592.

Hollin, C. R. (1995) The Meaning and Implications of 'Programme Integrity' Chap 10 in J. McGuire (Ed.) *What Works: Reducing Reoffending—Guidelines from Research and Practice*. London: John Wiley & Sons.

Hubbard, R. L., Marsden, M. E., Rachel, J. V., Cavanaugh, E. R., and Ginzburg, H. M. (1989) *Drug Abuse Treatment: A National Study Of Effectiveness*. Chapel Hill: Univ. NC Press.

Inciardi, J. A., Martin, S. S., Butzin, C. F., Hooper, R. M., Harrison, L. D. (1997) An effective model of prison-based treatment for drug-involved offenders. *Journal of Drug Issues,* 27(2), 261-278.

Lewis, B. F. & Ross, R. (1994) Retention in therapeutic communities: Challenge for the nineties. pp. 99-116 In F. M. Tims, G. De Leon & N. Jainchill (eds.) *Therapeutic Community: Advances in Research and Application*. NIDA Research Monograph No. 144. Washington: USGPO.

Lipton, D. S. (1997) Prison-based therapeutic community treatment programming. Presented at the Texas Commission on Alcohol and Drug Abuse Annual Institute of Alcohol and Drug Studies Summer Training, Austin, TX, July 23, 1997.

Marlatt, A. and Gordon, J. (1985) *Relapse Prevention Maintenance Strategies in Treatment of Addictive Disorders*. New York: Guilford.

McGuire & Priestly 1995

McLellan, A.T., Kushner, H.,Metzger, D., Peters, R., Smaith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992) The Fifth Edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment,* 9, 199-213.

Melnick, G. (1995) *A computerized instrument for client treatment matching.* Final Report, National Institute on Drug Abuse Grant No. 1R43 DA08972 New York: Center for Therapeutic Community Research at National Development and Research Institutes, Inc.

Molloy, J. P. (1992) *Self-Run, Self-Supported Houses for More Effective Recovery from Alcohol and Drug Addiction*. USHHS Technical Assistance Publication Series No. 5, Rockville MD: USGPO.

Platt, J. J.; Perry, G. M.; Metzger, D. S. (1980) The evolution of a heroin addiction treatment program within a correctional environment. In: R. R. Ross and P. Gendreau (eds.) *Effective Correctional Treatment*. Toronto: Butterworths.

Platt, J. J., Buhringer, G., Kaplan, C. D., Brown, B. S, Taube, D. O. (1988) The prospects and limitations of compulsory treatment for drug addiction. *Journal of Drug Issues,* 18, 505-526.

Porporino, F. J., Fabiano, E. A., Robinson, D. (1991) *Focusing on Successful Reintegration: Cognitive Skills Training for Offenders*. Research Report No. 19. Ottawa: Correctional Service of Canada.

Prochaska, J. O., DiClemente, C. C. & Norcross, J. C. (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist,* 47, 1102-1114.

Rawson, R. R., Obert, J. L., McCann, M. J., Smith, D. P., Ling, W. (1990) Neurobehavioral treatment for cocaine dependency. *Journal of Psychoactive Drugs*, 22, 159-171.

Robinson, D., Grossman, M., Porporino, F. J. (1991) *Effectiveness of the Cognitive Skills Training Program: From Pilot to National Implementation*. Ottawa: Correctional Service of Canada.

Robinson, D., 1995

Wexler, H. K., Falkin, G. P. & Lipton, D. S. (1988).*A Model Prison Rehabilitation Program: an Evaluation of the "Stay'n Out" Therapeutic Community*. Final Report to the National Institute on Drug Abuse. NY: Narcotic and Drug Research, Inc.

Wexler, H. K. (1995) The success of therapeutic communities for substance abusers in American prisons. *Journal of Psychoactive Drugs*, 27,3, 57-66.

Wish, E. D. & Gropper, B. (1990) Drug testing in the criminal justice system: Methods, research and applications. In M. J. Tonry & J. Q. Wilson (Eds.) *Drugs and Crime,* Crime & Justice Series, Vol. 13. Chicago: U. Chicago Press.

Wish, E. D. & O'Neil, J. A. (1991) Cocaine use in arrestees: Refining Measures of National Trends by Sampling the Criminal Population. In *The Epidemiology of Cocaine Use and Abuse,* NIDA Res. Monograph 110. Rockville MD: NIDA.